

4. Effective for inpatient admissions beginning on or after July 1, 1989 each facility designated a disproportionate share provider will have its rate based in accordance with paragraph VI.C.1. or VI.C.2. except --
  - (a) Using its most recent desk-reviewed cost report for the fiscal period ending in the calendar year preceding the rate determination date and,
  - (b) The operating component will be increased by the trend indices for the first prior fiscal year and current year as described in subsection I.F. of this regulation.
- D. Effective for inpatient admissions beginning in state fiscal year 1991, hospitals shall qualify as Disproportionate Share Hospitals and shall have rates established as provided for within this subsection.
  1. Hospitals shall qualify as First Tier Disproportionate Share Hospitals if --
    - (a) The hospital meets the criteria in paragraph VI.A.1., VI.A.2., and subparagraph VI.A.3.(b) or
    - (b) The hospital operated a neonatal intensive care unit with a ratio of Missouri Medicaid Neonatal patient days to Missouri Medicaid Total Patient Days in excess of nine percent (9%) reported or verified by the Division from the third prior year cost report.
  2. Hospitals shall qualify as second tier Disproportionate Share Hospitals if --
    - (a) The hospital meets the criteria established in paragraph VI.A.1. and paragraph VI.A.2. or
    - (b) The hospital annually provides more than ten thousand (10,000) Title XIX days of care and the Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days. This qualification shall be determined effective November 1, 1990 based on the 1989 cost report and annually thereafter on July 1 based on the most recent desk reviewed cost report ending in the preceding calendar year.
  3. The rate calculation for first and second tier disproportionate share hospitals shall be determined as follows subject to the adjustments described in paragraph VI.B.3.  $\rightarrow$  V.T.C. 1990

$$\text{Per Diem Rate} = \frac{\text{OC}}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

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- (a) OC-the operating component is the hospital's total allowable cost less CMC. Only the operating component will be increased by the trend indices for the first prior fiscal year and current year as described in subsection I.F. of this regulation;
- (b) CMC-the capital and medical education components of the hospital's total allowable cost;
- (c) MPD-the number of Medicaid inpatient billed days for service dates in the applicable cost report;
- (d) MPDC - MPD as defined previously with a minimum utilization of sixty percent as described in paragraph V.C.4; and
- (e) The per diem rate shall be increased by an additional ten percent (10%) if --
  - (1) The hospital has an unsponsored care ratio that exceeds sixty-five percent (65%). The ratio is determined as the sum of bad debts and charity care divided by total net revenues (TNR) as provided by the Missouri Hospital Association subject to verification by the Division of Medical Services; or
  - (2) Hospitals owned or operated by the Board of Curators or the Missouri Rehabilitation Center.

First tier disproportionate hospitals shall be exempt from length of stay limits except as they apply to General Relief Recipients. Allowable days for claim payment will be the medically necessary billed days of service for which the patient was Medicaid eligible.

The Division will not accept amended cost reports or other data necessary for qualification for disproportionate share hospital status or disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the Division's notification of the final determination of the rate.

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E. Effective for inpatient admissions beginning July 1, 1991, disproportionate share qualifications criteria, payment coverage, and rate setting shall be as described in subsection VI.D. except--

1. Disproportionate share 10% add-on hospitals, defined in subparagraph VI.D.3.(e), shall not have their disproportionate share rate reduced below the rate in effect on June 30, 1991.

VII.A. Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to disproportionate share hospitals, and for Missouri Medicaid-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met for the services to be eligible for outlier review:
  - (a) Services must have been provided in a hospital which is eligible to receive outlier adjustments;
    - (1) the hospital must have qualified as a disproportionate share status under Section VI of this plan and the patient was a Missouri Medicaid eligible child under the age of six (6) for all dates of services presented for review; or
    - (2) the patient must be a Missouri Medicaid eligible infant under the age of one (1) year for all dates of services presented for review; and
  - (b) one of the following conditions must be satisfied:
    - (1) the total reimbursable charges for dates of service as described in subparagraph VII.A.1.(a) must be at least one hundred fifty percent (150%) of the sum of total third party liabilities and Medicaid inpatient claim payments for said claim; or
    - (2) the dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by Medicaid.
2. Claims for all dates of services eligible for outlier review must:

- (a) have been submitted to the Division of Medical Services' fiscal agent in their entirety for routine claims processing and claims payments must have been made before the claims are submitted to the Division for outlier review; and
  - (b) be submitted for outlier review with all documentation as required by the Division of Medical Services no later than ninety (90) days for the last payment made by the fiscal agent through the normal claims processing system for those dates of services.
3. The claims will be reviewed for:
- (a) medical necessity at an inpatient hospital level of care;
  - (b) appropriateness of services provided in connection with the diagnosis; and
  - (c) charges that are not permissible per the Division of Medical Services' policies established in the institutional manual and hospital bulletins.
4. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by April 1 of each year or the cost report filed for the fiscal period in which the admission occurred if earlier:
- (a) average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and
  - (b) ancillary cost to charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.
  - (c) no cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

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5. Outlier adjustment payments for each hospital will be made during June of each State fiscal year for all claims submitted by March 1 which satisfies all conditions in paragraph VII.A.1., VII.A.2., and VII.A.3. of each fiscal year. The payments will be determined for each hospital as follows:
- (a) sum all reimbursable costs per paragraph VII.A.4. for all applicable outlier claims to equal total reimbursable costs;
  - (b) subtract third party payments and Medicaid payments for said claims from total reimbursable costs to equal excess cost;
  - (c) multiply excess costs by 50%.
- B. Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to disproportionate share hospitals, and for Missouri Medicaid-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

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**VIII. Payment Assurance**

- A. The state will pay each hospital, which furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the regulations implementing the Hospital Reimbursement Program.
- B. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of State Programs such as Vocational Rehabilitation and the Bureau for Special Health Care Needs. Procedures for remitting third party payments are provided in the Missouri Medical Assistance Program Provider Manuals.

When the Missouri Medicaid agency determines the existence of third party liability at the time a claim is filed, the agency rejects the claim and returns it to the provider for a determination of the amount of liability. When the amount of liability is determined, Medicaid then pays the claim to the extent that payment allowed under Missouri Medicaid's payment schedule exceeds the amount of the third party's payment.

For inpatient hospital services provided for an individual entitled to Medicare Part A benefits and eligible for Medicaid, Medicaid's payment will be limited to the lower of Medicare's coinsurance and deductible amounts or the amount Medicaid's payment schedule exceeds Medicare's payment.

- C. Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

**IX. Provider Participation**

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of hospitals in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public.

**X. Payment in Full**

Participation in the program shall be limited to the hospitals who accept, as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with the regulations implementing the hospital reimbursement program.

**XI. Plan Evaluation**

Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan amendment.

### XII. Inappropriate Placements

- A. The hospital per-diem rates as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when he is only in need of nursing home care.
1. If a hospital has an established ICF/SNF or SNF only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNF only rate.
  2. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement of nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.
  3. No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

### XIII. Out-of-State and In-State Federally-Operated Hospital Reimbursement

- A. Effective for admissions beginning on or after July 1, 1987, inpatient services for hospitals located outside the State of Missouri and federally-operated hospitals located within the state of Missouri will be reimbursed at the lower of --
1. The charges for those services; or
  2. The individual recipient's days of care (within benefit limitations) multiplied by the Title XIX per-diem rate established July 1, 1986, as the weighted average per-diem rate determined for Missouri facilities (excluding state mental health facilities and federally-operated hospitals) as of June 1, 1986 as increased by the annual inflation index for in-state hospitals calculated in accordance with section I. of this rule.
- B. There will be no adjustments or exemptions to this per-diem rate and no individual rate reconsideration will be performed.

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- C. Payments on claims submitted, unless otherwise specified, constitute final payment to hospitals located outside the state of Missouri and to federally-operated hospitals within the state of Missouri on those claims and no year-end cost settlements will be done. Therefore, these hospitals are not required to file Medicaid cost reports with the state of Missouri.

XIV. Reimbursement for inpatient hospital services associated with an admission for the surgical performance of only those human organ and bone marrow transplantations as defined in Attachment 3.1-E is made on the basis of reasonable cost of providing the services as defined and determined by the Division of Medical Services.

The methodology defined in this attachment in sections I. through XIV. for all other inpatient hospital services reimbursement is not applicable to these specific services. Inpatient hospital costs associated with these services are excluded from the per-diem reimbursement rate computation.

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